



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 23, 2008

Philip Herink
Sunhealth Behavioral of Boise
8050 Northview Street
Boise, Idaho 83704

Provider #134009

Dear Mr. Herink:

On **September 18, 2008**, a complaint survey was conducted at Sunhealth Behavioral Of Boise. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003695

Allegation #1: Patient's power of attorney's and/or their family's were not included in discharge planning.

Findings: An unannounced visit was made to the hospital on 9/16/08. Six clinical records and hospital policies were reviewed. Additionally, staff were interviewed and patient cares were observed.

The hospital's "SOCIAL SERVICES DISCHARGE AND AFTERCARE OF PATIENTS" policy dated 2006, stated the hospital's goal was "to provide patients with ongoing discharge planning from their admission to their discharge and aftercare treatment appropriate to their needs." Further, the policy stated, "Requirements for discharge for each patient shall be developed by the interdisciplinary treatment team. The development of an initial discharge plan will begin with the formulation of the initial treatment plan which will be completed within 24 hrs. of the patient's admission. The discharge criteria shall be commensurate with the presenting problems and bases upon medical, psychiatric, and psychological evaluations.

Re-evaluation of the discharge plan based on the initial treatment plan shall occur with the formulation of the patient's comprehensive treatment plan and will be reassessed throughout the patient's hospitalization and will become more detailed as more information is obtained through interdisciplinary evaluations based on the patient's global situation... Final discharge/aftercare planning shall occur when the interdisciplinary treatment team agrees that the patient is nearing completion of his/her inpatient goals and objectives. An inherent component of discharge planning is the patient and/or family's input which shall reflect his or her progress and plans for continuing treatment or supportive services after discharge."

The hospital's "REFERRAL SOURCES" policy stated, "Discharge referral planning is coordinated by the assigned case manager in conjunction with the primary physician, nursing, activities personnel and other members of the treatment team. The assigned case manager will consult with the patient, the patient's family when applicable, and other members of the treatment team to explore what services are desirable and available."

Of the six records reviewed on 9/16/08 all six records documented in treatment meeting notes, social worker notes and nursing notes complete adherence to above policies. The records documented that there was family involvement throughout each of the patients' care and discharge planning. Further, it was documented that families were encouraged to participate and exercised their rights for discharge planning. Additionally, the patients' records documented that multiple aftercare facilities were contacted per family's requests.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients who needed feeding assistance did not receive help from staff.

Findings: Six clinical records were reviewed. One patient's record documented an 96- year-old male that was admitted on 3/26/08, with a diagnosis of dementia with behaviors. He was discharged on 4/23/08. The record contained a "Nutritional Risk Review" dated 4/1/08 (un-timed), by the facility's Dietitian that stated the patient was not eating and needed feeding assistance from the staff. The Dietitian also noted that the patient would refuse breakfast and sleep in. On 4/1/08 (un-timed), the dietitian noted in the "Dietary Progress Notes" the patient was eating 25 to 50% of his meals. On 4/9/08 (un-timed), the dietitian noted in the "Dietary Progress Notes" the patient was eating 75% of his meals and continued to need help. On 4/1/08 (un-timed), the dietitian noted in the "Dietary Progress Notes", the patient was refusing "Breakfast likes to sleep and refuses other meals and does refuse snacks, eating an average of 50% of lunch and dinner. Needs encouragement help with tray set up". On 4/22/08 (un-timed), the dietitian noted in the "Dietary Progress Notes", the patient was still refusing breakfast but was eating 45 to 100% of his other meals.

She also documented the patient was then eating snacks and still only needed help with tray setup.

On 9/17/07 at 8:15 AM, a visit was made to the dining room to observe the morning meal. Ten patients were in the dining room for the meal. Breakfast consisted of pancakes, sausage, oatmeal juice, milk, water and coffee. Four staff members were present to serve the breakfast and assist patients with eating. One staff member was observed to be cutting the pancakes and sausage into bite size pieces while another staff member served the trays to patients. The third and fourth staff member were observed be feeding three patients who needed total assistance with their meals. Staff documented the percentage of the meal each patient ate and the amount of fluid consumed.

Three staff members were interviewed on 9/17/07 around 9:30 AM. Each staff member stated that they circulate through the dining room and encouraged patients to eat and drink.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients who were incontinent were left wet and soiled for extended periods of time causing skin breakdown.

Findings: Six clinical records were reviewed, staff were interviewed and observations were made. All six records reviewed contained a "CNA Daily Flow Sheet of Patient Care". The flow sheets documented that patients incontinent briefs were changed up to 6 times a shift and patients were also toileted.

Three staff members were interviewed on 9/17/07 around 9:30 AM. Each staff member stated that incontinent patients briefs/pads were checked before and after breakfast, before and after lunch and every two hours or more if needed. They also stated that they would often try to toilet patients.

Observations were made from 9/16 through 9/17/08. It was observed that staff did check on and provide routine incontinent care to patients as stated above.

One patient's record documented a 96-year-old male that was admitted on 3/26/08. The patient's primary diagnosis was dementia with behaviors. He was discharged on 4/23/08. His admission nursing assessment, dated 3/26/08 (un-timed), documented the patient was incontinent of bowel and bladder. It further documented the patient upon admission had ecchymoses (skin irritation), on his groin and back side. The physician's assistant ordered medications for the patient's skin on 3/27/08 and followed the treatment of the patient's skin irritation throughout the patient's admission.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients were denied coffee.

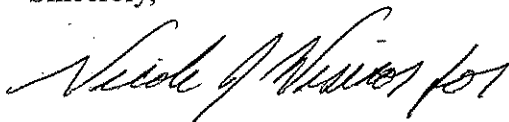
Findings: On 9/17/07 at 8:15 AM, a visit was made to the dining room to observe the morning meal. Ten patients were in the dining room for the meal. Breakfast consisted of pancakes, sausage, oatmeal juice, milk, water and coffee. Four staff members were present to serve the breakfast and assist patients with eating. One staff member was observed to be cutting the pancakes and sausage into bite size pieces while another staff member served the trays to patients and refilled 2 patients' coffee cups. The third and fourth staff member were observed be feeding three patients' who needed total assistance with their meals.

Three staff members were interviewed on 9/17/07 around 9:30 AM. Each staff member stated that they circulate through the dining room and encouraged patients to eat and drink and that if patients wanted coffee, more was provided.

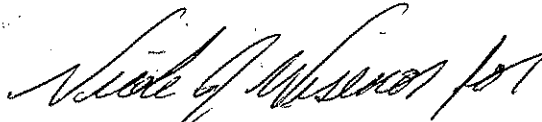
Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw



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September 23, 2008

Philip Herink
Sunhealth Behavioral of Boise
8050 Northview Street
Boise, Idaho 83704

Provider #134009

Dear Mr. Herink:

On **September 18, 2008**, a complaint survey was conducted at Sunhealth Behavioral Of Boise. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003775

Allegation #1: The hospital transferred patients to other facilities without necessary background medical information.

Findings: On 9/16/08, surveyors made an unannounced visit to the hospital. During the complaint investigation, surveyors reviewed hospital policies, grievances, incident reports, 6 medical records from the hospital and 1 medical record from another hospital that accepted a transfer patient. In addition, surveyors interviewed hospital staff, ambulance staff, and a physician from a secondary hospital.

The hospital had two policies that addressed the expectation that hospital staff would provide copies of background patient information to outside facilities. These policies addressed patients being transferred to other facilities and patients transported to appointments.

The first policy, Patient Transfer to Another Facility (form NS.2.2, dated 9/16/2004), stated "all patient documents relating to the patient's hospitalization that will promote continuity of quality patient care, will accompany the patient to the receiving facility."

The policy provided multiple examples of types of records that may accompany the patient. Examples included but were not limited to: 1) a patient transfer form; 2) lab and x-ray reports; 3) face sheet; 4) history and physical; 5) psychiatric and/or psychosocial evaluations; 6) physician's orders; 7) nursing and therapy notes; and 8) transfer summary. The policy further stated that the transfer summary would be completed with a current list of medications and double noted.

A second policy, Transportation of Patients for Outside Services (NS.2.3, dated 9/16/2004), addressed the expectation that hospital staff would provide background patient information to the receiving facility, including: 1) history and physical; 2) medication record; 3) Do Not Resuscitate/Do Not Intubate (DNR/DNI) consent. These records were to be provided even if the patient were being transported for an appointment or procedure.

The hospital's Policy and Procedure Manual contained an undated form, Patient Transfer Orders (S.S.5.3), that staff were to complete for transfers. Some of the information to be completed on the form included demographic information, medication orders, allergies, treatment orders, and a nursing transfer assessment.

The hospital failed to ensure transfer policies were implemented and that patient transfer orders were completed as follows:

One patient was an 85 year old male with a primary diagnosis of dementia and a history of agitation. On 9/9/08, he was transferred to the Emergency Department (ED) of another hospital for evaluation of symptoms and a computed tomography (CT) scan upon request of the patient's son. The patient's medical record did not include documentation to indicate any medical records were copied and sent with the ambulance service that transported the patient to the ED.

During an interview on 9/16/08 at 3:30 PM, the Director of Nursing Services (DNS) stated that a transfer form was not likely sent with the patient because the patient was expected to return to their facility after the evaluation and CT scan. She stated that she expected staff would have copied and sent relevant medical information with the transport personnel for delivery to the receiving facility. She explained it was not their practice to document in the chart that information was provided for transfer.

During an interview on 9/16/08 at 3:45 PM, the charge nurse who prepared the patient for transfer on 9/9/08, stated that he made copies of records, placed them in an envelope and gave them to the ambulance service for transport to the hospital. He reported that he did not document in the patient's chart that he provided copies of information.

During a phone interview on 9/17/08 at 8:30 AM, a licensed practical nurse (LPN) stated she saw the charge nurse making copies of information for the transfer but did not see whether the information was given to the paramedics at the time of the transfer.

During a phone interview on 9/17/08 at 8:50 AM, the owner of the ambulance service stated that the ambulance record did not show any documentation that information had been transported along with the patient from the hospital to the ED. During a second phone interview on 9/17/08 at 9:40 AM, the owner stated the ambulance driver who transported the patient denied receiving any paperwork from the hospital to transport. However, he acknowledged receiving a verbal report on the patient.

During a phone interview on 9/17/08 at 9:50 AM, a Physician Assistant (PA) stated that an ED physician called him to ask why the patient was sent to the ED and what they wanted to have done for the patient. He provided the physician with a verbal report over the phone.

The secondary hospital's 9/9/08 & 9/10/08 clinical records for the above mentioned patient indicated the only medical information that was received was a hand written list of medications.

During a phone interview on 9/17/08 at 3:00 PM, the physician from the secondary hospital confirmed that the patient arrived with a hand written list of medications and no medical records.

Surveyors reviewed two additional records involving patients who were transferred to secondary facilities. There was no documentation found in either record to indicate any medical records were copied and sent during transfer of patients. Also, neither record contained a copy of the Patient Transfer Order. During an interview on 9/16/08 at 2:25 PM, the Director of Nursing Service reviewed the records and confirmed that documentation was missing in the clinical record to confirm that medical records were copied and sent or that a Patient Transfer form was completed.

The hospital was issued a deficiency at A0837 for failure to ensure that patients were transferred, along with necessary medical information to outside facilities.

Conclusion: Substantiated: Federal deficiencies related to allegation are cited.

Allegation #2: A unprescribed pain patch was applied to a patient.

Findings: During an interview on 9/16/08 at 3:00 PM, a pharmacist explained that: 1) the hospital carefully monitored narcotic inventory, such as pain patches; 2) narcotics were locked; 3) both pharmacists and registered nurses counted narcotics regularly to ensure proper inventory; 4) nurses checked patients every 6 hours to ensure pain patches were on patients and the results were recorded on the medication administration record.

During an interview on 9/17/08 at 8:15 AM, a second pharmacist denied awareness of any missing or misapplied pain patches in the previous several weeks. She stated that the pharmacy count for pain patch inventory had appropriately matched the expected inventory.

During an interview on 9/16/08 at 4:00 PM, a licensed practical nurse stated that nurses checked pain patches every 4 hours and any missing patches were immediately reported to pharmacy services. She denied awareness of any missing pain patches.

During an interview on 9/16/08 at 3:30 PM, the Director of Nursing Service explained that it was the practice of hospital staff to complete an incident report if any pain patches were determined to be missing or misapplied. She denied any awareness of any pain patches being applied to a patient who did not have one ordered.

Surveyors reviewed incident reports for June through September of 2008. None of the documented hospital incidents during these months related to misapplied or missing pain patches.

Surveyors reviewed 6 hospital records. One record documented an 85 year old male with a primary diagnosis of dementia and a history of agitation. He was transferred on 9/9/08 from the hospital to the Emergency Department of another hospital for evaluation of symptoms and a computed tomography scan upon the request of the patient's son who was concerned about his father's symptoms.

During a phone interview on 9/17/08 at 10:30 AM, surveyors spoke with the son of the identified patient. He explained that he received a call from a hospital physician on 9/9/08, the day his father was transferred to another hospital. During the phone call, the physician reportedly asked him why his father was on a pain patch. He (the patient's son) told the physician that he was unaware of any pain patch. To follow-up, the son called the original hospital to ask if his father was on a pain patch and if so why. Nursing staff told him that his father was not on a pain patch. The son wondered if his father had a pain patch on his body that had not been prescribed and if that explained why his father's condition had deteriorated.

During a phone interview on 9/17/08 at 3:00 PM, a physician who treated the above mentioned patient at the secondary hospital on 9/9/08 reported that she called the patient's son to clarify some patient information because no medical records arrived with the patient "except a hand written medication list." She stated: 1) she thought the list indicated that the patient was on a pain patch; 2) she called the son to find out why the patient was on a pain patch; 3) she denied seeing a pain patch on the patient's body; 4) the son reported to her that he did not know of his father being on any pain patch.

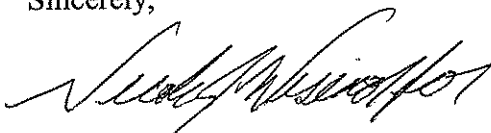
No documentation was found in the Emergency Department record dated 9/9/08 and 9/10/08 to indicate the above identified patient had a pain patch on his body. Therefore, it could not be substantiated that an unprescribed pain patch was applied to the above mentioned patient. Further, none of the other 5 patient records documented the application of unprescribed pain patches. The allegation was, therefore, unsubstantiated.

Conclusion: Unsubstantiated. Allegation did not occur.

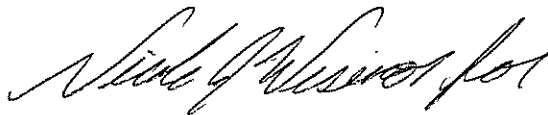
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw



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September 23, 2008

Philip Herink
Sunhealth Behavioral Of Boise
8050 Northview Street
Boise, Idaho 83704

RE: Sunhealth Behavioral Of Boise, provider #134009

Dear Mr. Herink:

This is to advise you of the findings of the complaint survey at Sunhealth Behavioral Of Boise which was concluded on September 18, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

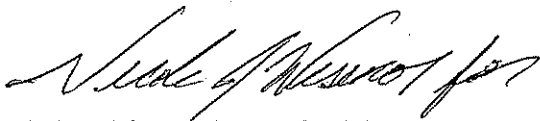
1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Philip Herink
September 23, 2008
Page 2 of 2

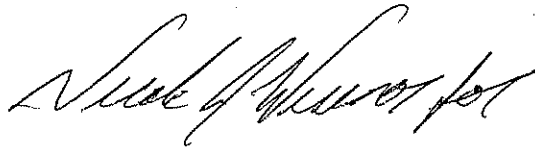
After you have completed your Plan of Correction, return the original to this office by **October 6, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,



PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

SunHealth



SunHealth Behavioral Health System for Boise 8050 Northview St
Boise, ID 83704
208.327.0504
Fax 208.327.0594

October 6, 2008

Ms. Sylvia Crestwell, Co-Supervisor
Non Long Term Care
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

VIA FACSIMILE: 208-364-1888 Total of 7 pages

Dear Ms. Crestwell,

Pursuant to the letter received on September 23, 2008 I hereby submit the 2567 with a plan of correction for the survey conducted on September 18, 2008. Submission of this plan of correction does not constitute an admission of the facts alleged or the conclusions set forth in any subsequent Statements of Deficiencies.

If you should have any questions regarding this plan of correction please don't hesitate to contact me at 327-0504 x 204.

Sincerely,


Philip Herink
CEO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2008
NAME OF PROVIDER OR SUPPLIER SUNHEALTH BEHAVIORAL OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation of your hospital. The surveyors conducting the complaint investigation were: Patrick Henderson, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: CT - Computed Tomography DNR/DNI - Do Not Resuscitate/Do Not Intubate DNS - Director of Nursing Service ED - Emergency Department LPN - Licensed Practical Nurse MARS - Medication Administration Record PA - Physician Assistant POA - Power of Attorney RN - Registered Nurse	A 000		
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on review of medical records and hospital policies, and interviews with staff, it was determined the hospital failed to transfer patients with necessary medical information to outside facilities in 3 of 3 transferred patients (#'s 1, 3, and 6) whose records were reviewed. This failure interfered with continuity of patient care and resulted in one patient (#1) being delayed in receiving prescribed medication at the secondary	A 837	Sun Health hospital has developed a transfer check list that will be utilized by the charge nurse to assure that all necessary information is sent with a patient transferring to an acute care hospital, and a copy will be placed in the chart. All Licensed nursing staff will be in-serviced on the use of the form. The Director of Nurses will audit all acute care transfers to ensure that all necessary information has been sent and the form is utilized correctly. Results will be presented to the Quality Assurance Committee.	10/06/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 837	<p>Continued From page 1</p> <p>hospital. This deficient practice had the potential to interfere with continuity and quality of care in all patients who were transferred. Findings include:</p> <p>1. The hospital had two policies that addressed the expectation that hospital staff provide background patient information to outside facilities. Policies addressed patients being transferred to other facilities and patients being transported to appointments.</p> <p>The first policy, Patient Transfer to Another Facility (form NS.2.2, dated 9/16/2004), stated "all patient documents relating to the patient's hospitalization that will promote continuity of quality patient care, will accompany the patient to the receiving facility." The policy provided multiple examples of types of records that may accompany the patient. Examples included but were not limited to: 1) patient transfer form; 2) lab and x-ray reports; 3) face sheet; 4) history and physical; 5) psychiatric and/or psychosocial evaluations; 6) physician's orders; 7) nursing and therapy notes; and 8) transfer summary. The policy further stated that the transfer summary would be completed with a current list of medications and double noted.</p> <p>A second policy, Transportation of Patients for Outside Services (NS.2.3, dated 9/16/2004), addressed patients who were transported for an appointment or procedure. The hospital expected staff to provide background information, including a history and physical, medication record, and DNR/DNI consent to the receiving facility.</p> <p>The hospital's Policy and Procedure Manual contained an undated form, Patient Transfer Orders (S.S.5.3), that hospital staff were</p>	A 837			

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NAME OF PROVIDER OR SUPPLIER SUNHEALTH BEHAVIORAL OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
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A 837	<p>Continued From page 2</p> <p>expected to complete for transfers. Some of the information to be completed on the form included demographic information, medication orders, allergies, treatment orders, and a nursing transfer assessment.</p> <p>The hospital failed to ensure transfer policies were implemented and that patient transfer orders were completed as follows:</p> <p>A. Patient #1 was an 85 year old male with a primary diagnosis of dementia and a history of agitation. According to documentation in the clinical record: 1) The patient was transferred on 9/9/08 to the ED of another hospital for evaluation of symptoms and a CT scan; 2) The transfer was initiated upon the request of the patient's son who was concerned about changes in his father's condition; 3) The son was concerned that the symptoms his father was having could have been related to an aneurysm that had been previously diagnosed; 4) The son insisted that his father be evaluated immediately.</p> <p>The medical record for patient #1 did not include documentation to indicate any medical records were copied and sent with the ambulance service that transported the patient to the ED.</p> <p>During an interview on 9/16/08 at 3:30 PM, the DNS stated that a transfer form was not likely sent with the patient because the patient was expected to return after the evaluation and CT scan. She stated that she expected staff would have copied and sent relevant medical information with the transport personnel for delivery to the receiving facility. Specifically, she expected the following information would have accompanied the patient: the order, medication</p>	A 837		
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NAME OF PROVIDER OR SUPPLIER SUNHEALTH BEHAVIORAL OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
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A 837	<p>Continued From page 3</p> <p>list, copy of the MARS, and possibly a psychiatric evaluation and history and physical. When asked how she would know if the information had been copied and sent, she responded that she would not know unless she interviewed the nurse. She explained it was not hospital practice to document in the chart that information was provided for transfer.</p> <p>During an interview of 9/16/08 at 3:45 PM, the charge nurse who prepared the patient for transfer on 9/9/08, stated that he made copies of records, placed them in an envelope and gave them to the ambulance service for transport to the hospital. He reported that he did not document in the patient's chart that he provided copies of information. However, he explained, it would have been typical for him to copy "all pertinent papers," such as a medication list, nursing notes, history and physical, consults, and labs.</p> <p>During a phone interview on 9/17/08 at 8:30 AM, an LPN stated she saw the charge nurse making copies of information for the transfer but did not see whether the information was given to the paramedics at the time of the transfer.</p> <p>During a phone interview on 9/17/08 at 8:50 AM, the owner of the ambulance service stated that the ambulance record did not show any documentation that a packet of information had been transported along with the patient from the hospital to the ED. During a second phone interview on 9/17/08 at 9:40 AM, the owner stated that the ambulance driver who transported the patient denied receiving any paperwork from the hospital. However, he did acknowledge receiving a verbal report on the patient.</p>	A 837			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/18/2008
NAME OF PROVIDER OR SUPPLIER SUNHEALTH BEHAVIORAL OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
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A 837	<p>Continued From page 4</p> <p>During a phone interview on 9/17/08 at 9:50 AM, a PA stated that an ED physician called him to ask why the patient had been sent to the ED and what they wanted done for the patient. The PA provided the physician with a verbal report over the phone.</p> <p>Surveyors obtained and reviewed copies of the secondary hospital's 9/9/10 & 9/10/08 patient records for patient #1. Results of the record review indicated the secondary hospital did not receive medical records. A physician's History and Physical report, dated 9/9/08 stated that the patient had a "hand written list of medications" but "unfortunately" there were "no other records for the patient" and she did "not know how reliable this list is." A physician's order, dated 9/9/08 8:15 PM stated "Get records from [(hospital name)]. Need list of medications tonight please." A separate note on 9/9/08 stated "will get records from [hospital name] and continue medications when they are known."</p> <p>During a phone interview on 9/17/08 at 3:00 PM, the physician from the secondary facility confirmed that the patient arrived with a hand written list of medications and no medical records. She stated that the hand written list of medications was not clear to her.</p> <p>The hospital failed to provide necessary background information to the secondary facility during transfer.</p> <p>B. Patient #3 was an 86-year-old male who was admitted on 7/24/08 with a diagnosis of dementia with behaviors. On 8/26/08, the patient's physician ordered the patient to be transported to a secondary hospital because the patient was</p>	A 837			

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A 837	<p>Continued From page 5</p> <p>"extremely dehydrated and unresponsive." The record did not contain documented evidence that any medical records were copied and sent with the patient to the hospital. The record did not contain the hospital's "Patient Transfer Orders" form. On 9/16/08 at 2:25 PM, the DNS reviewed the record. She confirmed that the record did not contain evidence that any medical records were copied and sent with the patient nor did the record contain a "Patient Transfer Orders" form.</p> <p>The hospital failed to provide necessary background information to the secondary hospital during patient transfer.</p> <p>C. Patient #6 was a 94-year-old male that was admitted on 8/23/08 with a diagnosis of aggressive behaviors. On 8/27/08, the patient's physician ordered the patient to be transported to a secondary hospital because the patient suffered a thumb injury. The record did not contain documented evidence that any medical records were copied and sent with the patient to the hospital. The record did not contain the hospital's "Patient Transfer Orders" form. On 9/16/08 at 2:30 PM, the DNS reviewed the record. She confirmed that the record did not contain evidence that any medical records were copied and sent with the patient nor did the record contain a "Patient Transfer Orders" form.</p> <p>The hospital failed to provide necessary background information to the secondary hospital during patient transfer.</p>	A 837			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 10X811

Facility ID: ID5ENT

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